than 15 days in medication coverage. Three statistical models corresponding to the three measures of medication refill persistence were performed: Tobit model, logistic regression, and survival analysis. Control variables included demographic and social economic information, health status, medication conditions, health service utilization, and drug benefit characteristics. **RESULTS:** The study included 1549 members, 42.0% female, mean age 55.7 years, with member cost-sharing of about $12 per 30 days supply. For every $1 increase in 30 day average cost-sharing, total gap increased by 2.7% (transferred Tobit coefficient = 0.027, 95% CI = [0.011, 0.043], p = 0.001); the odds of non-persistence (PDC < 80%) increased by 2.5% (OR = 1.025, 95% CI = [1.007, 1.042], p = 0.005); and the risk to have a gap of more than 15 days increased by 1.7% (HR = 1.017, 95% CI = [1.007, 1.027], p = 0.001). **CONCLUSION:** Prescription cost-sharing was associated with a significant and negative impact on medication refill persistence after controlling for other confounders. It is important for health plans and self insured employers to consider the implications of member contribution on medication refill persistence when making pharmacy benefit design decisions.

**CV3**

### LONG-TERM HEALTH OUTCOMES FOR PATIENTS HOSPITALIZED WITH UNSTABLE ANGINA AND NSTEMI IN THE CALIFORNIA MEDICAID POPULATION: ASSESSMENT OF CLOPIDOGREL THERAPY IN ACS

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**OBJECTIVES:** To evaluate the long-term health outcomes of ACS patients taking clopidogrel and aspirin, either alone or in combination, within the California Medicaid population. **METHODS:** A retrospective claims study was conducted for the 10-year period from 1995–2004. Patients were ≥19 years of age, with ≥6 months of continuous eligibility prior to index date, and ≥1 month of continuous eligibility after index date. Patients hospitalized with UA or NSTEMI were identified using ICD-9 codes and divided into 3 subgroups: clopidogrel-only (CO), aspirin-only (AO), and clopidogrel/aspirin (CA). Cox proportional-hazard models were used to estimate hazard ratios (HR) for time to death, major bleeding events (MBE; ICD-9 codes 531.x1–535.x1), re-hospitalization, and revascularization with covariate adjustment. The unadjusted time-to-event curves were estimated using Kaplan-Meier (KM) techniques. **RESULTS:** The UA/NSTEMI study population included 6448 patients. KM curves showed no difference in time to MBE among the 3 groups. With AO (n = 3738) serving as the baseline, HR for CA (n = 2071) was 1.05 (P = 0.65); HR for CO (n = 639) was 0.985 (P = 0.93). The KM curves for CO and AO showed no difference in time to death. However, HR for CA was 0.706 (P = 0.0030), indicating that patients taking both drugs had a roughly 30% lower risk of death compared with patients taking AO. In contrast, CA had a 50% higher risk of re-hospitalization (HR = 1.50, P < 0.0001) and revascularization (HR = 1.51, P < 0.0001) than AO. No statistically significant differences in risk were found between CO and AO for re-hospitalization (HR = 0.80, P = 0.18) or revascularization (HR = 1.18, P = 0.18). **CONCLUSION:** The results suggest patients taking clopidogrel or aspirin, either alone or in combination, have similar long-term bleeding risk. The combination of clopidogrel and aspirin may reduce the risk of death compared with either drug alone. However, combination therapy did not lead to a decrease in re-hospitalization or revascularization compared with either drug alone.

**CV4**

### THE IMPACT OF A CALCIUM CHANNEL BLOCKER PREFERRED DRUG LIST ON MEDICAID PRESCRIPTION EXPENDITURES AND UTILIZATION

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**OBJECTIVES:** On July 12, 2005 the Arkansas Medicaid program implemented a prior approval policy for calcium channel blockers (CCBs) in which Diltiazem ER, Dynacirc CR, Nifedipine ER, XL, CC, CR, Norvasc, and Verapamil SR, SA, were the preferred drugs. The objective of this study was to estimate the impact of this policy on CCB expenditures. **METHODS:** This study utilized a time series panel design to evaluate the impact of the policy using Arkansas Medicaid administrative claims data obtained from January 2003 through May 2006. Auto-Regressive Integrated Moving Average (ARIMA) time series models were specified using monthly prescription expenditures and utilization in the pre-policy period (January 2003–June 2005) to forecast expenditures and utilization in the post-policy period. The Medicaid payer perspective was used and all prescription costs were calculated based on the amount paid for each claim adjusted for product specific CMS rebates. **RESULTS:** The average forecast expenditures for CCBs for August 2005–May 2006 was $426,706 (95%CI: 410,356–443,055) per month and observed expenditures were $331,547 indicating that the policy change was associated with a 22% reduction in CCB expenditures or $95,159 (95%CI: 78,809–111,508) per month. The average monthly savings were $114,521 prior to January 2006 and were $75,796 after Medicare dual eligibles began receiving Part-D benefits. Non-significant reductions in CCB utilization were observed in the initial 4 months following the policy, however by May 2006, 4065 (95%CI: 3811–4319) recipients were expected to be taking CCBs but only 3046 actually had a CCB prescription filled. **CONCLUSION:** This CCB preferred drug list resulted in substantial savings of approximately $100,000 per month. Some of the savings appear to be a result of reduced utilization of CCBs which may indicate that other cardiovascular drugs may have been used in place of CCBs or CCB discontinuation.

## PODIUM SESSION I: MEDICARE PART D

**MD1**

### WHAT IF THE FEDERAL SUPPLY SCHEDULE SET PHARMACEUTICAL PRICES FOR SENIORS?

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**OBJECTIVES:** The Medicare Modernization Act explicitly ruled out the possibility that the federal government could directly negotiate drug prices as an effective way to contain costs for Part D. Recent changes in the leadership of congress have led to a reemergence of debate on this issue. Taking a societal perspective, we sought to quantify how much money for prescription drugs could be saved among the elderly if prices nationwide were equivalent to 2006 Federal Supply Schedule (FSS) prices for several of the top selling prescription drug classes. **METHODS:** Cross-sectional analysis of the nationally representative Medical Expenditure Panel Survey, 2004. Adults > 64 years who filled a prescription for any drug within the following classes were included: Angiotensin Receptor Blockers, ACE inhibitors, HMG-CoA Reductase Inhibitors (Statins), Proton Pump Inhibitors, Non-Steroidal Anti-inflammatory, Histamine-2 Receptor Antagonists, Dihydropyridine Calcium Channel Blockers, and Steroid Inhalers (n = 2198 individuals). The average price/pill for each